

The Drugless Doctors

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2001 Crocker Rd. #100 • Westlake, OH 44145 • 440.471.4200 • druglessdrs.com

Practice Member Name: _____

Date: _____

Terms of Acceptance

Informed Consent:

A practice member, in coming to the chiropractic doctor, gives the doctor permission and authority to care for the practice member in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the practice member susceptible to injury. The doctor, of course, will not give any treatment or care if he/she is aware that such care may be contra-indicated. Again, it is the responsibility of the practice member to make it known, or to learn through healthcare procedures what he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the chiropractic physician. The chiropractic doctor provides a specialized, non-duplicating health care service. Your doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regimen. I understand that if I am accepted as a practice member by a physician at The Drugless Doctors, I am authorizing them to proceed with any treatment that they deem necessary.

Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

Circle one

Women Only:

Circle one

To the best of my knowledge (I am / am NOT) pregnant and (give permission / don't give permission) to x-ray me for diagnostic interpretation.
Pregnancy Complications: _____

Missed Appointments:

There is a possible cancellation fee charged for appointments that are not canceled in advance. Visits missed while on a care plan must be made up within the time frame of the care plan.

Guarantee of Results:

The purpose of chiropractic care is to improve the health and function of the spine and nervous system. It is not to treat disease, suppress symptoms, medically diagnose, perform surgery or prescribe medications. If you desire any of these we will gladly refer you for those services. Practice member acknowledges that any and all questions regarding benefits, risks and alternatives have been answered to their satisfaction.

Communications:

In the event that we would need to communicate your healthcare information, to whom may we do so?

Spouse: _____ Children: _____ Others: _____ No one: _____

Please indicate if our office can leave a message on your voicemail regarding your personal health information. Y [] N []

Please indicate if we can text office updates in the case of weather alerts or special office announcements. Y [] N []

Please indicate if we can send email information to the provided email address through unsecure means. Y [] N []

Preferred Communication Voicemail Y/N Text Y/N Email Y/N

Release of Medical Information:

I certify that I (or my dependent) assign directly to The Drugless Doctors all insurance benefits, if any, otherwise payable to me for services rendered. I hereby authorize this office to release any information requested by my insurance company to document my claim for benefits. I understand that I am personally responsible for full payment of all charges for my treatment. Services are payable at the time rendered. X-rays remain the property of this clinic and will only be released to another physician after receiving a proper release authorization request from said physician. X-ray will not be released directly to practice members.

Determination of Treatment:

I understand and agree that the doctors of The Drugless Doctors have the right to decline or accept me as a practice member at any time before treatment begins. Taking a history and conducting an examination are a part of the process of information gathering, so that the doctor can determine whether to admit me as a practice member or not.

Minor Consent:

I am authorized to and do consent to all treatments performed by the doctors and staff of The Drugless Doctors and rendered to the minor practice member named on this registration form.

Acknowledgement:

I have read and fully understand the above statements. I have received and/or reviewed the notice of privacy practices (**HIPAA-Posted at druglessdrs.com/new-member-info**) and understand that I have the opportunity to discuss my right to privacy upon request.

Print Name: _____ Signature: _____ Date: _____

Name: _____ File Number: _____ Date: _____

Please **CIRCLE** a number to rate each function below.

	0= <u>BEST</u>										10= <u>WORST</u>
1. Overall Quality of Life:	0	1	2	3	4	5	6	7	8	9	10
2. Sleep Habits:	0	1	2	3	4	5	6	7	8	9	10
3. Energy Levels:	0	1	2	3	4	5	6	7	8	9	10
4. Behavior:	0	1	2	3	4	5	6	7	8	9	10
5. Attention:	0	1	2	3	4	5	6	7	8	9	10
6. Activity Levels:	0	1	2	3	4	5	6	7	8	9	10
7. Co-ordination:	0	1	2	3	4	5	6	7	8	9	10
8. Appetite:	0	1	2	3	4	5	6	7	8	9	10
9. Digestion/Bowel (BM):	0	1	2	3	4	5	6	7	8	9	10
10. # of complaints:	0	1	2	3	4	5	6	7	8	9	10
11. Colds/Infections:	0	1	2	3	4	5	6	7	8	9	10
12. Breathing:	0	1	2	3	4	5	6	7	8	9	10

Questions/Concerns/Other: _____

This section is to indicate areas of DISCOMFORT and DYSFUNCTION in the body.

Please use the letter **N** for **NECK**, **M** for **MID BACK**, and **L** for **LOW BACK**. If you have challenges in other areas, please write the letter **X**, and indicate that body region here: _____ (ex: X=Shoulder). For each of the 11 scenarios below, rate your discomfort in each body region by writing the letters **N**, **M**, and **L** (and **X** if applicable)—**even if you have no discomfort/dysfunction in that area**. See example below.

EXAMPLE:		(Mid back)		(Neck)		(Low back)				
Travel (Driving, etc.)	0	M	2	4	N	6	8	L	10	
	No discomfort		Some		Mild		Moderate		Severe	Worst discomfort

1. Discomfort Intensity	0	2	4	6	8	10	No discomfort	Some	Mild	Moderate	Severe	Worst discomfort
2. During Sleep	0	2	4	6	8	10	Perfect sleep	Occasionally disturbed	Mildly disturbed	Moderately disturbed	Greatly disturbed	Cannot sleep
3. Personal Care (Washing, Dressing, etc.)	0	2	4	6	8	10	No challenges	Can do < 100%	Can do 75%	Can do 50%	Need assistance	Cannot do at all
4. Travel (Driving, etc.)	0	2	4	6	8	10	No discomfort	Some	Mild	Moderate	Severe	Worst discomfort
5. Work	0	2	4	6	8	10	Can do 100% + extra	Can do 100%	Can do 75%	Can do 50%	Can do 25%	Cannot work at all
6. Recreation	0	2	4	6	8	10	Can do all + more	Can do 100%	Can do 75%	Can do 50%	Can do 25%	Cannot do any activities
7. Discomfort Frequency	0	2	4	6	8	10	No discomfort	Infrequently	Occasionally	Intermittently	Frequently	Constant discomfort
8. Lifting	0	2	4	6	8	10	No restrictions	Some trouble	Cannot lift heavy	Cannot lift moderate	Cannot lift light	Cannot lift any weight
9. Walking	0	2	4	6	8	10	Can walk any distance	Challenge > 2 miles	Challenge > 1mile	Challenge > ½ mile	Challenge > ¼ mile	Cannot walk
10. Standing	0	2	4	6	8	10	No challenge > 3+hrs	Challenge > 3+ hrs	Challenge > 2 hrs	Challenge > 1hr	Challenge > 30min	Cannot stand
11. Sitting	0	2	4	6	8	10	No challenge > 3+hrs	Challenge > 3+ hrs	Challenge > 2 hrs	Challenge > 1hr	Challenge > 30min	Cannot sit

Practice Member Signature: _____

Date: _____

Dr. Signature: _____

Date: _____